**Prepared by John Nakashima, Ph.D., MSW**
**Program Analyst, Community Care, VA Greater Los Angeles HCS**

## CHALENG 2005 Survey: VA Central California HCS, CA - 570

## A. Homeless Veteran Estimates:

### 1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 3322

### 2. Estimated Number of Veterans who are Chronically Homeless: 764

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 3322 (estimated number of homeless veterans in service area) **x chronically homeless rate (23 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

## B. Data from the Point of Contact Survey

### 1. Housing Inventory

| Housing Inventory | Beds | # of additional beds site could use |
|---|---|---|
| Emergency Beds | 1532 | 0 |
| Transitional Housing Beds | 100 | 150 |
| Permanent Housing Beds | 217 | 150 |

### 2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 6

### 3. CHALENG Point of Contact Action Plan for FY 2005

| | |
|---|---|
| Transitional living facility or halfway house | We are developing transitional beds throughout the Fresno community. There are many motels and apartments that can become shared housing. Working with local agencies for support. |
| Long-term, permanent housing | Will engage HUD and other community resources. We will support and write grants to address this need. |
| Women's Health care | Already including women as priority in all our outreach efforts. Linking with current women's services to assure that they will refer women veterans to our homeless program. |

## C. Data from the CHALENG Participant Survey

**Number of Participant Surveys**: **46** **Non-VA staff Participants: 64.9%**
**Homeless/Formerly Homeless**: **23.9%**

### 1. Needs Ranking (1=Need Unmet .... 5= Need Met)

| Need | Site Mean Score | *% want to work on this need now | VHA Mean** Score (all VA sites) |
|---|---|---|---|
| Personal hygiene | 3.31 | 9.0% | 3.47 |
| Food | 3.44 | 13.0% | 3.80 |
| Clothing | 3.54 | 3.0% | 3.61 |
| Emergency (immediate) shelter | 2.84 | 29.0% | 3.33 |
| Halfway house or transitional living facility | 2.58 | 35.0% | 3.07 |
| Long-term, permanent housing | 1.89 | 61.0% | 2.49 |
| Detoxification from substances | 2.54 | 22.0% | 3.41 |
| Treatment for substance abuse | 3.03 | 16.0% | 3.55 |
| Services for emotional or psychiatric problems | 3.2 | 6.0% | 3.46 |
| Treatment for dual diagnosis | 2.9 | 3.0% | 3.30 |
| Family counseling | 2.50 | 3.0% | 2.99 |
| Medical services | 3.61 | 6.0% | 3.78 |
| Women's health care | 3.00 | 3.0% | 3.23 |
| Help with medication | 3.20 | 6.0% | 3.46 |
| Drop-in center or day program | 2.40 | 10.0% | 2.98 |
| AIDS/HIV testing/counseling | 3.06 | .0% | 3.51 |
| TB testing | 3.63 | .0% | 3.71 |
| TB treatment | 3.39 | .0% | 3.57 |
| Hepatitis C testing | 3.65 | 3.0% | 3.63 |
| Dental care | 2.11 | 23.0% | 2.59 |
| Eye care | 2.44 | .0% | 2.88 |
| Glasses | 2.22 | .0% | 2.88 |
| VA disability/pension | 3.36 | 6.0% | 3.40 |
| Welfare payments | 3.03 | .0% | 3.03 |
| SSI/SSD process | 3.03 | .0% | 3.10 |
| Guardianship (financial) | 2.64 | .0% | 2.85 |
| Help managing money | 2.28 | .0% | 2.87 |
| Job training | 2.71 | .0% | 3.02 |
| Help with finding a job or getting employment | 2.89 | 10.0% | 3.14 |
| Help getting needed documents or identification | 3.40 | 3.0% | 3.28 |
| Help with transportation | 2.78 | 3.0% | 3.02 |
| Education | 2.86 | 10.0% | 3.00 |
| Child care | 2.19 | 3.0% | 2.45 |
| Legal assistance | 2.74 | 3.0% | 2.71 |
| Discharge upgrade | 3.03 | 3.0% | 3.00 |
| Spiritual | 3.41 | 9.0% | 3.36 |
| Re-entry services for incarcerated veterans | 2.65 | 6.0% | 2.72 |
| Elder Healthcare | 2.82 | .0% | 3.06 |

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

## 2. Level of Collaboration Activities Between VA and Community

| **Implementation Scale**<br>**1 = None**, no steps taken to initiate implementation of the strategy.<br>**2 = Low**, in planning and/or initial minor steps taken.<br>**3 = Moderate**, significant steps taken but full implementation not achieved.<br>**4 = High**, strategy fully implemented. | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **Interagency Coordinating Body** - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services. | 2.00 |
| **Co-location of Services** - Services from the VA and your agency provided in one location. | 1.68 |
| **Cross-Training** - Staff training about the objectives, procedures and services of the VA and your agency. | 1.80 |
| **Interagency Agreements/ Memoranda of Understanding** - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services. | 1.90 |
| **Interagency Client Tracking Systems/ Management Information Systems** - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access. | 1.65 |
| **Pooled/Joint Funding** - Combining or layering funds from the VA and your agency to create new resources or services. | 1.35 |
| **Uniform Applications, Eligibility Criteria, and Intake Assessments** – Standardized form that the client fills out only once to apply for services at the VA and your agency. | 1.61 |
| **Interagency Service Delivery Team/ Provider Coalition** - Service team comprised of staff from the VA and your agency to assist clients with multiple needs. | 1.70 |
| **Consolidation of Programs/ Agencies** - Combining programs from the VA and your agency under one administrative structure to integrate service delivery. | 1.83 |
| **Flexible Funding** – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients. | 1.58 |
| **Use of Special Waivers** - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services. | 1.47 |
| **System Integration Coordinator Position** - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development. | 1.79 |

## 3. VA/Community Integration

| **Integration Scale:**<br>1 (low) to 5 (high) | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **VA Accessibility**: In general, how accessible do you feel VA services are to homeless veterans in the community? | 3.29 |
| **VA Service Coordination**: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency. | 2.95 |

**Prepared by John Nakashima, Ph.D., MSW**
**Program Analyst, Community Care, VA Greater Los Angeles HCS**

# CHALENG 2005 Survey: VA Northern California HCS - 612 (Martinez, Oakland and Sacramento)

## A. Homeless Veteran Estimates:

### 1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 7800

### 2. Estimated Number of Veterans who are Chronically Homeless: 3978

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 7800 (estimated number of homeless veterans in service area) **x chronically homeless rate (51 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

## B. Data from the Point of Contact Survey

### 1. Housing Inventory

| Housing Inventory | Beds | # of additional beds site could use |
|---|---|---|
| Emergency Beds | 430 | 60 |
| Transitional Housing Beds | 200 | 100 |
| Permanent Housing Beds | 15 | 300 |

### 2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 20

### 3. CHALENG Point of Contact Action Plan for FY 2005

| | |
|---|---|
| Long-term, permanent housing | Working with Contra Costa County to increase access to beds . |
| Detoxification from substances | Working with VA mental health and Contra Costa County to increase services for detoxification. |
| Dental care | Working with VA Dental Service to increase access. |

## C. Data from the CHALENG Participant Survey

**Number of Participant Surveys**: **61** **Non-VA staff Participants: 75.0%**
**Homeless/Formerly Homeless**: **47.5%**

### 1. Needs Ranking (1=Need Unmet .... 5= Need Met)

| Need | Site Mean Score | *% want to work on this need now | VHA Mean** Score (all VA sites) |
|---|---|---|---|
| Personal hygiene | 3.30 | 4.0% | 3.47 |
| Food | 3.63 | 6.0% | 3.80 |
| Clothing | 3.16 | 4.0% | 3.61 |
| Emergency (immediate) shelter | 2.93 | 39.0% | 3.33 |
| Halfway house or transitional living facility | 3.02 | 14.0% | 3.07 |
| Long-term, permanent housing | 2.21 | 63.0% | 2.49 |
| Detoxification from substances | 3.19 | 18.0% | 3.41 |
| Treatment for substance abuse | 3.45 | 14.0% | 3.55 |
| Services for emotional or psychiatric problems | 3.1 | 10.0% | 3.46 |
| Treatment for dual diagnosis | 3.0 | 14.0% | 3.30 |
| Family counseling | 2.77 | 2.0% | 2.99 |
| Medical services | 3.42 | 10.0% | 3.78 |
| Women's health care | 2.71 | 4.0% | 3.23 |
| Help with medication | 3.05 | 4.0% | 3.46 |
| Drop-in center or day program | 2.79 | .0% | 2.98 |
| AIDS/HIV testing/counseling | 2.98 | .0% | 3.51 |
| TB testing | 3.42 | .0% | 3.71 |
| TB treatment | 3.25 | .0% | 3.57 |
| Hepatitis C testing | 3.07 | .0% | 3.63 |
| Dental care | 2.13 | 24.0% | 2.59 |
| Eye care | 2.86 | .0% | 2.88 |
| Glasses | 2.74 | 6.0% | 2.88 |
| VA disability/pension | 2.96 | 4.0% | 3.40 |
| Welfare payments | 2.67 | .0% | 3.03 |
| SSI/SSD process | 2.55 | 6.0% | 3.10 |
| Guardianship (financial) | 2.51 | 2.0% | 2.85 |
| Help managing money | 2.82 | 2.0% | 2.87 |
| Job training | 2.84 | 10.0% | 3.02 |
| Help with finding a job or getting employment | 2.80 | 14.0% | 3.14 |
| Help getting needed documents or identification | 3.15 | .0% | 3.28 |
| Help with transportation | 3.22 | 4.0% | 3.02 |
| Education | 2.80 | 6.0% | 3.00 |
| Child care | 2.21 | 2.0% | 2.45 |
| Legal assistance | 2.43 | 6.0% | 2.71 |
| Discharge upgrade | 2.41 | 4.0% | 3.00 |
| Spiritual | 2.60 | 6.0% | 3.36 |
| Re-entry services for incarcerated veterans | 2.57 | .0% | 2.72 |
| Elder Healthcare | 2.63 | 2.0% | 3.06 |

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

## 2. Level of Collaboration Activities Between VA and Community

| **Implementation Scale**<br>**1 = None**, no steps taken to initiate implementation of the strategy.<br>**2 = Low**, in planning and/or initial minor steps taken.<br>**3 = Moderate**, significant steps taken but full implementation not achieved.<br>**4 = High**, strategy fully implemented. | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **Interagency Coordinating Body** - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services. | 3.22 |
| **Co-location of Services** - Services from the VA and your agency provided in one location. | 2.42 |
| **Cross-Training** - Staff training about the objectives, procedures and services of the VA and your agency. | 2.46 |
| **Interagency Agreements/ Memoranda of Understanding** - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services. | 3.05 |
| **Interagency Client Tracking Systems/ Management Information Systems** - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access. | 2.05 |
| **Pooled/Joint Funding** - Combining or layering funds from the VA and your agency to create new resources or services. | 2.73 |
| **Uniform Applications, Eligibility Criteria, and Intake Assessments** – Standardized form that the client fills out only once to apply for services at the VA and your agency. | 2.46 |
| **Interagency Service Delivery Team/ Provider Coalition** - Service team comprised of staff from the VA and your agency to assist clients with multiple needs. | 3.08 |
| **Consolidation of Programs/ Agencies** - Combining programs from the VA and your agency under one administrative structure to integrate service delivery. | 2.71 |
| **Flexible Funding** – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients. | 2.11 |
| **Use of Special Waivers** - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services. | 1.97 |
| **System Integration Coordinator Position** - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development. | 2.79 |

## 3. VA/Community Integration

| **Integration Scale:**<br>1 (low) to 5 (high) | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **VA Accessibility**: In general, how accessible do you feel VA services are to homeless veterans in the community? | 3.40 |
| **VA Service Coordination**: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency. | 3.66 |

**Prepared by John Nakashima, Ph.D., MSW**
**Program Analyst, Community Care, VA Greater Los Angeles HCS**

# CHALENG 2005 Survey: VA Palo Alto HCS (VAMC Livermore - 640A4 and VAMC Palo Alto - 640), Menlo Park, CA

## A. Homeless Veteran Estimates:

### 1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 4000

### 2. Estimated Number of Veterans who are Chronically Homeless: 1600

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 4000 (estimated number of homeless veterans in service area) **x chronically homeless rate (40 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

## B. Data from the Point of Contact Survey

### 1. Housing Inventory

| Housing Inventory | Beds | # of additional beds site could use |
|---|---|---|
| Emergency Beds | 350 | 200 |
| Transitional Housing Beds | 376 | 300 |
| Permanent Housing Beds | 200 | 500 |

### 2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 20

### 3. CHALENG Point of Contact Action Plan for FY 2005

| | |
|---|---|
| Long-term, permanent housing | Work with community to develop and fund housing. |
| Transitional living facility or halfway house | Continue to seek community funding. |
| Treatment for dual diagnosis | Work with community on improved access to dual diagnosis treatment and development of resources. |

## C. Data from the CHALENG Participant Survey

**Number of Participant Surveys**: **17** **Non-VA staff Participants: 100.0%**
**Homeless/Formerly Homeless**: **5.9%**

### 1. Needs Ranking (1=Need Unmet .... 5= Need Met)

| Need | Site Mean Score | *% want to work on this need now | VHA Mean** Score (all VA sites) |
|---|---|---|---|
| Personal hygiene | 2.69 | 15.0% | 3.47 |
| Food | 3.87 | 8.0% | 3.80 |
| Clothing | 3.79 | 8.0% | 3.61 |
| Emergency (immediate) shelter | 2.81 | 31.0% | 3.33 |
| Halfway house or transitional living facility | 3.13 | 23.0% | 3.07 |
| Long-term, permanent housing | 2.38 | 62.0% | 2.49 |
| Detoxification from substances | 2.36 | 15.0% | 3.41 |
| Treatment for substance abuse | 2.53 | 23.0% | 3.55 |
| Services for emotional or psychiatric problems | 3.0 | 8.0% | 3.46 |
| Treatment for dual diagnosis | 3.0 | 15.0% | 3.30 |
| Family counseling | 3.14 | .0% | 2.99 |
| Medical services | 3.57 | 15.0% | 3.78 |
| Women's health care | 2.85 | .0% | 3.23 |
| Help with medication | 3.29 | .0% | 3.46 |
| Drop-in center or day program | 3.00 | .0% | 2.98 |
| AIDS/HIV testing/counseling | 3.08 | .0% | 3.51 |
| TB testing | 3.58 | .0% | 3.71 |
| TB treatment | 3.42 | .0% | 3.57 |
| Hepatitis C testing | 3.31 | .0% | 3.63 |
| Dental care | 2.62 | 15.0% | 2.59 |
| Eye care | 2.77 | .0% | 2.88 |
| Glasses | 2.77 | 8.0% | 2.88 |
| VA disability/pension | 3.83 | 8.0% | 3.40 |
| Welfare payments | 3.67 | .0% | 3.03 |
| SSI/SSD process | 2.83 | 8.0% | 3.10 |
| Guardianship (financial) | 2.83 | .0% | 2.85 |
| Help managing money | 2.71 | .0% | 2.87 |
| Job training | 3.13 | .0% | 3.02 |
| Help with finding a job or getting employment | 3.27 | 15.0% | 3.14 |
| Help getting needed documents or identification | 3.38 | .0% | 3.28 |
| Help with transportation | 3.07 | .0% | 3.02 |
| Education | 2.86 | .0% | 3.00 |
| Child care | 2.36 | 8.0% | 2.45 |
| Legal assistance | 3.00 | .0% | 2.71 |
| Discharge upgrade | 3.58 | .0% | 3.00 |
| Spiritual | 3.62 | .0% | 3.36 |
| Re-entry services for incarcerated veterans | 2.50 | 8.0% | 2.72 |
| Elder Healthcare | 3.08 | 8.0% | 3.06 |

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

## 2. Level of Collaboration Activities Between VA and Community

| **Implementation Scale**<br>**1 = None**, no steps taken to initiate implementation of the strategy.<br>**2 = Low**, in planning and/or initial minor steps taken.<br>**3 = Moderate**, significant steps taken but full implementation not achieved.<br>**4 = High**, strategy fully implemented. | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **Interagency Coordinating Body** - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services. | 2.44 |
| **Co-location of Services** - Services from the VA and your agency provided in one location. | 1.75 |
| **Cross-Training** - Staff training about the objectives, procedures and services of the VA and your agency. | 1.82 |
| **Interagency Agreements/ Memoranda of Understanding** - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services. | 2.33 |
| **Interagency Client Tracking Systems/ Management Information Systems** - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access. | 1.67 |
| **Pooled/Joint Funding** - Combining or layering funds from the VA and your agency to create new resources or services. | 1.69 |
| **Uniform Applications, Eligibility Criteria, and Intake Assessments** – Standardized form that the client fills out only once to apply for services at the VA and your agency. | 1.56 |
| **Interagency Service Delivery Team/ Provider Coalition** - Service team comprised of staff from the VA and your agency to assist clients with multiple needs. | 2.25 |
| **Consolidation of Programs/ Agencies** - Combining programs from the VA and your agency under one administrative structure to integrate service delivery. | 2.00 |
| **Flexible Funding** – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients. | 1.40 |
| **Use of Special Waivers** - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services. | 1.47 |
| **System Integration Coordinator Position** - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development. | 1.63 |

## 3. VA/Community Integration

| **Integration Scale:**<br>1 (low) to 5 (high) | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **VA Accessibility**: In general, how accessible do you feel VA services are to homeless veterans in the community? | 3.53 |
| **VA Service Coordination**: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency. | 3.29 |

**Prepared by John Nakashima, Ph.D., MSW**
**Program Analyst, Community Care, VA Greater Los Angeles HCS**

## CHALENG 2005 Survey: VA Sierra Nevada HCS, NV - 654

## A. Homeless Veteran Estimates:

### 1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 300

### 2. Estimated Number of Veterans who are Chronically Homeless: 51

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 300 (estimated number of homeless veterans in service area) **x chronically homeless rate (17 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

## B. Data from the Point of Contact Survey

### 1. Housing Inventory

| Housing Inventory | Beds | # of additional beds site could use |
|---|---|---|
| Emergency Beds | 187 | 130 |
| Transitional Housing Beds | 625 | 32 |
| Permanent Housing Beds | 477 | 78 |

### 2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

### 3. CHALENG Point of Contact Action Plan for FY 2005

| | |
|---|---|
| Long-term, permanent housing | The city of Reno along with members of the Reno Alliance for Homeless are working on a 5-year strategy to address affordable permanent housing along with economic development. |
| Detoxification from substances | The Co-occurring Disorders/Triage Committee is working on plans to open a Triage Center with approximately 4000 square feet in the new Emergency Shelter Building. This is designed to offer alternatives to incarceration and unclog local emergency rooms. |
| SSI/SSD Process | HCHV is currently working with Social Security and organizations who represent clients seeking SSI/SSD |

## C. Data from the CHALENG Participant Survey

**Number of Participant Surveys**: **6 Non-VA staff Participants: 80.0%**
**Homeless/Formerly Homeless**: **16.7%**

**1. Needs Ranking (1=Need Unmet .... 5= Need Met)**

| Need | Site Mean Score | *% want to work on this need now | VHA Mean** Score (all VA sites) |
|---|---|---|---|
| Personal hygiene | 3.50 | .0% | 3.47 |
| Food | 3.50 | 17.0% | 3.80 |
| Clothing | 4.00 | .0% | 3.61 |
| Emergency (immediate) shelter | 3.17 | 17.0% | 3.33 |
| Halfway house or transitional living facility | 2.50 | 33.0% | 3.07 |
| Long-term, permanent housing | 2.33 | 67.0% | 2.49 |
| Detoxification from substances | 2.67 | 33.0% | 3.41 |
| Treatment for substance abuse | 2.83 | 17.0% | 3.55 |
| Services for emotional or psychiatric problems | 3.4 | .0% | 3.46 |
| Treatment for dual diagnosis | 2.8 | 17.0% | 3.30 |
| Family counseling | 2.83 | .0% | 2.99 |
| Medical services | 4.20 | .0% | 3.78 |
| Women's health care | 2.83 | 17.0% | 3.23 |
| Help with medication | 3.67 | .0% | 3.46 |
| Drop-in center or day program | 2.67 | .0% | 2.98 |
| AIDS/HIV testing/counseling | 3.50 | .0% | 3.51 |
| TB testing | 4.17 | .0% | 3.71 |
| TB treatment | 4.00 | .0% | 3.57 |
| Hepatitis C testing | 3.83 | .0% | 3.63 |
| Dental care | 2.50 | .0% | 2.59 |
| Eye care | 2.00 | 17.0% | 2.88 |
| Glasses | 2.00 | .0% | 2.88 |
| VA disability/pension | 3.17 | .0% | 3.40 |
| Welfare payments | 2.67 | .0% | 3.03 |
| SSI/SSD process | 2.83 | 50.0% | 3.10 |
| Guardianship (financial) | 2.50 | .0% | 2.85 |
| Help managing money | 3.00 | .0% | 2.87 |
| Job training | 3.17 | .0% | 3.02 |
| Help with finding a job or getting employment | 3.00 | .0% | 3.14 |
| Help getting needed documents or identification | 2.50 | 17.0% | 3.28 |
| Help with transportation | 2.50 | .0% | 3.02 |
| Education | 3.00 | .0% | 3.00 |
| Child care | 2.17 | .0% | 2.45 |
| Legal assistance | 2.83 | .0% | 2.71 |
| Discharge upgrade | 2.67 | .0% | 3.00 |
| Spiritual | 3.33 | .0% | 3.36 |
| Re-entry services for incarcerated veterans | 2.67 | .0% | 2.72 |
| Elder Healthcare | 2.83 | .0% | 3.06 |

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

## 2. Level of Collaboration Activities Between VA and Community

| **Implementation Scale**<br>**1 = None**, no steps taken to initiate implementation of the strategy.<br>**2 = Low**, in planning and/or initial minor steps taken.<br>**3 = Moderate**, significant steps taken but full implementation not achieved.<br>**4 = High**, strategy fully implemented. | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **Interagency Coordinating Body** - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services. | 3.00 |
| **Co-location of Services** - Services from the VA and your agency provided in one location. | 1.25 |
| **Cross-Training** - Staff training about the objectives, procedures and services of the VA and your agency. | 2.50 |
| **Interagency Agreements/ Memoranda of Understanding** - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services. | 3.25 |
| **Interagency Client Tracking Systems/ Management Information Systems** - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access. | 1.50 |
| **Pooled/Joint Funding** - Combining or layering funds from the VA and your agency to create new resources or services. | 1.75 |
| **Uniform Applications, Eligibility Criteria, and Intake Assessments** – Standardized form that the client fills out only once to apply for services at the VA and your agency. | 1.75 |
| **Interagency Service Delivery Team/ Provider Coalition** - Service team comprised of staff from the VA and your agency to assist clients with multiple needs. | 2.75 |
| **Consolidation of Programs/ Agencies** - Combining programs from the VA and your agency under one administrative structure to integrate service delivery. | 1.50 |
| **Flexible Funding** – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients. | 1.25 |
| **Use of Special Waivers** - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services. | 1.75 |
| **System Integration Coordinator Position** - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development. | 1.75 |

## 3. VA/Community Integration

| **Integration Scale:**<br>1 (low) to 5 (high) | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **VA Accessibility**: In general, how accessible do you feel VA services are to homeless veterans in the community? | 2.75 |
| **VA Service Coordination**: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency. | 4.25 |

**Prepared by John Nakashima, Ph.D., MSW**
**Program Analyst, Community Care, VA Greater Los Angeles HCS**

## CHALENG 2005 Survey: VAM&ROC Honolulu, HI - 459

## A. Homeless Veteran Estimates:

### 1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 800

### 2. Estimated Number of Veterans who are Chronically Homeless: 208

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 800 (estimated number of homeless veterans in service area) **x chronically homeless rate (26 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

## B. Data from the Point of Contact Survey

### 1. Housing Inventory

| Housing Inventory | Beds | # of additional beds site could use |
|---|---|---|
| Emergency Beds | 270 | 30 |
| Transitional Housing Beds | 200 | 50 |
| Permanent Housing Beds | 110 | 50 |

### 2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

### 3. CHALENG Point of Contact Action Plan for FY 2005

| | |
|---|---|
| Long-term, permanent housing | Develop 12 long-term, permanent housing beds at Barbers Point. |
| Transportation | Requested assistance from D.A.V. Also worked with city to develop an additional two special bus routes. |
| Help managing Money | Develop relationship with veteran-focused payee service. |

## C. Data from the CHALENG Participant Survey

**Number of Participant Surveys**: **16** **Non-VA staff Participants: 43.8%**
**Homeless/Formerly Homeless**: **.0%**

**1. Needs Ranking (1=Need Unmet .... 5= Need Met)**

| Need | Site Mean Score | *% want to work on this need now | VHA Mean** Score (all VA sites) |
|---|---|---|---|
| Personal hygiene | 2.75 | .0% | 3.47 |
| Food | 3.69 | 7.0% | 3.80 |
| Clothing | 3.69 | 13.0% | 3.61 |
| Emergency (immediate) shelter | 2.88 | 27.0% | 3.33 |
| Halfway house or transitional living facility | 2.56 | 33.0% | 3.07 |
| Long-term, permanent housing | 1.94 | 69.0% | 2.49 |
| Detoxification from substances | 3.50 | 13.0% | 3.41 |
| Treatment for substance abuse | 3.93 | .0% | 3.55 |
| Services for emotional or psychiatric problems | 3.9 | 13.0% | 3.46 |
| Treatment for dual diagnosis | 3.6 | .0% | 3.30 |
| Family counseling | 2.40 | .0% | 2.99 |
| Medical services | 3.80 | 20.0% | 3.78 |
| Women's health care | 3.21 | .0% | 3.23 |
| Help with medication | 3.36 | 7.0% | 3.46 |
| Drop-in center or day program | 2.29 | 13.0% | 2.98 |
| AIDS/HIV testing/counseling | 3.29 | 7.0% | 3.51 |
| TB testing | 3.50 | .0% | 3.71 |
| TB treatment | 3.29 | .0% | 3.57 |
| Hepatitis C testing | 3.71 | .0% | 3.63 |
| Dental care | 1.64 | 13.0% | 2.59 |
| Eye care | 2.21 | 7.0% | 2.88 |
| Glasses | 2.07 | 7.0% | 2.88 |
| VA disability/pension | 3.50 | .0% | 3.40 |
| Welfare payments | 3.38 | .0% | 3.03 |
| SSI/SSD process | 3.14 | .0% | 3.10 |
| Guardianship (financial) | 2.80 | .0% | 2.85 |
| Help managing money | 2.87 | .0% | 2.87 |
| Job training | 3.31 | 13.0% | 3.02 |
| Help with finding a job or getting employment | 3.47 | 31.0% | 3.14 |
| Help getting needed documents or identification | 3.33 | .0% | 3.28 |
| Help with transportation | 2.73 | .0% | 3.02 |
| Education | 2.53 | .0% | 3.00 |
| Child care | 1.40 | .0% | 2.45 |
| Legal assistance | 2.33 | 7.0% | 2.71 |
| Discharge upgrade | 2.86 | .0% | 3.00 |
| Spiritual | 3.31 | .0% | 3.36 |
| Re-entry services for incarcerated veterans | 2.40 | .0% | 2.72 |
| Elder Healthcare | 2.33 | 7.0% | 3.06 |

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

## 2. Level of Collaboration Activities Between VA and Community

| **Implementation Scale**<br>**1 = None**, no steps taken to initiate implementation of the strategy.<br>**2 = Low**, in planning and/or initial minor steps taken.<br>**3 = Moderate**, significant steps taken but full implementation not achieved.<br>**4 = High**, strategy fully implemented. | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **Interagency Coordinating Body** - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services. | 3.40 |
| **Co-location of Services** - Services from the VA and your agency provided in one location. | 2.80 |
| **Cross-Training** - Staff training about the objectives, procedures and services of the VA and your agency. | 2.00 |
| **Interagency Agreements/ Memoranda of Understanding** - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services. | 3.20 |
| **Interagency Client Tracking Systems/ Management Information Systems** - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access. | 2.40 |
| **Pooled/Joint Funding** - Combining or layering funds from the VA and your agency to create new resources or services. | 2.00 |
| **Uniform Applications, Eligibility Criteria, and Intake Assessments** – Standardized form that the client fills out only once to apply for services at the VA and your agency. | 2.60 |
| **Interagency Service Delivery Team/ Provider Coalition** - Service team comprised of staff from the VA and your agency to assist clients with multiple needs. | 3.00 |
| **Consolidation of Programs/ Agencies** - Combining programs from the VA and your agency under one administrative structure to integrate service delivery. | 2.60 |
| **Flexible Funding** – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients. | 1.75 |
| **Use of Special Waivers** - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services. | 1.75 |
| **System Integration Coordinator Position** - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development. | 2.25 |

## 3. VA/Community Integration

| **Integration Scale:**<br>1 (low) to 5 (high) | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **VA Accessibility**: In general, how accessible do you feel VA services are to homeless veterans in the community? | 3.71 |
| **VA Service Coordination**: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency. | 4.29 |

**Prepared by John Nakashima, Ph.D., MSW**
**Program Analyst, Community Care, VA Greater Los Angeles HCS**

## CHALENG 2005 Survey: VAMC San Francisco, CA - 662

## A. Homeless Veteran Estimates:

### 1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 3000

### 2. Estimated Number of Veterans who are Chronically Homeless: 1440

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 3000 (estimated number of homeless veterans in service area) **x chronically homeless rate (48 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

## B. Data from the Point of Contact Survey

### 1. Housing Inventory

| Housing Inventory | Beds | # of additional beds site could use |
|---|---|---|
| Emergency Beds | 400 | 100 |
| Transitional Housing Beds | 110 | 50 |
| Permanent Housing Beds | 415 | 200 |

### 2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

### 3. CHALENG Point of Contact Action Plan for FY 2005

| | |
|---|---|
| Long-term, permanent housing | Ongoing work with city and community agencies. |
| Detoxification from substances | Work with city to develop new beds. |
| Treatment for dual diagnosis | Ongoing. |

## C. Data from the CHALENG Participant Survey

**Number of Participant Surveys**: **38** **Non-VA staff Participants: 94.1%**
**Homeless/Formerly Homeless**: **23.7%**

### 1. Needs Ranking (1=Need Unmet .... 5= Need Met)

| Need | Site Mean Score | *% want to work on this need now | VHA Mean** Score (all VA sites) |
|---|---|---|---|
| Personal hygiene | 3.29 | 3.0% | 3.47 |
| Food | 3.62 | 6.0% | 3.80 |
| Clothing | 3.44 | .0% | 3.61 |
| Emergency (immediate) shelter | 3.11 | 28.0% | 3.33 |
| Halfway house or transitional living facility | 2.64 | 31.0% | 3.07 |
| Long-term, permanent housing | 1.97 | 55.0% | 2.49 |
| Detoxification from substances | 3.21 | 13.0% | 3.41 |
| Treatment for substance abuse | 3.31 | 22.0% | 3.55 |
| Services for emotional or psychiatric problems | 2.8 | 19.0% | 3.46 |
| Treatment for dual diagnosis | 2.7 | 9.0% | 3.30 |
| Family counseling | 2.65 | .0% | 2.99 |
| Medical services | 3.57 | 3.0% | 3.78 |
| Women's health care | 3.23 | 3.0% | 3.23 |
| Help with medication | 2.89 | .0% | 3.46 |
| Drop-in center or day program | 3.25 | .0% | 2.98 |
| AIDS/HIV testing/counseling | 3.12 | .0% | 3.51 |
| TB testing | 3.34 | .0% | 3.71 |
| TB treatment | 3.31 | .0% | 3.57 |
| Hepatitis C testing | 3.23 | .0% | 3.63 |
| Dental care | 2.21 | 25.0% | 2.59 |
| Eye care | 2.26 | 3.0% | 2.88 |
| Glasses | 2.18 | 6.0% | 2.88 |
| VA disability/pension | 3.15 | 16.0% | 3.40 |
| Welfare payments | 2.76 | .0% | 3.03 |
| SSI/SSD process | 2.71 | 3.0% | 3.10 |
| Guardianship (financial) | 2.35 | .0% | 2.85 |
| Help managing money | 2.69 | 3.0% | 2.87 |
| Job training | 2.63 | 13.0% | 3.02 |
| Help with finding a job or getting employment | 3.06 | 13.0% | 3.14 |
| Help getting needed documents or identification | 3.32 | .0% | 3.28 |
| Help with transportation | 2.74 | 3.0% | 3.02 |
| Education | 2.79 | 3.0% | 3.00 |
| Child care | 2.52 | .0% | 2.45 |
| Legal assistance | 2.38 | 9.0% | 2.71 |
| Discharge upgrade | 2.53 | 6.0% | 3.00 |
| Spiritual | 2.61 | 3.0% | 3.36 |
| Re-entry services for incarcerated veterans | 2.38 | .0% | 2.72 |
| Elder Healthcare | 2.50 | .0% | 3.06 |

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

## 2. Level of Collaboration Activities Between VA and Community

| **Implementation Scale**<br>**1 = None**, no steps taken to initiate implementation of the strategy.<br>**2 = Low**, in planning and/or initial minor steps taken.<br>**3 = Moderate**, significant steps taken but full implementation not achieved.<br>**4 = High**, strategy fully implemented. | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **Interagency Coordinating Body** - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services. | 2.81 |
| **Co-location of Services** - Services from the VA and your agency provided in one location. | 2.26 |
| **Cross-Training** - Staff training about the objectives, procedures and services of the VA and your agency. | 1.94 |
| **Interagency Agreements/ Memoranda of Understanding** - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services. | 2.52 |
| **Interagency Client Tracking Systems/ Management Information Systems** - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access. | 1.61 |
| **Pooled/Joint Funding** - Combining or layering funds from the VA and your agency to create new resources or services. | 1.97 |
| **Uniform Applications, Eligibility Criteria, and Intake Assessments** – Standardized form that the client fills out only once to apply for services at the VA and your agency. | 1.90 |
| **Interagency Service Delivery Team/ Provider Coalition** - Service team comprised of staff from the VA and your agency to assist clients with multiple needs. | 2.29 |
| **Consolidation of Programs/ Agencies** - Combining programs from the VA and your agency under one administrative structure to integrate service delivery. | 2.13 |
| **Flexible Funding** – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients. | 1.77 |
| **Use of Special Waivers** - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services. | 1.66 |
| **System Integration Coordinator Position** - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development. | 1.79 |

## 3. VA/Community Integration

| **Integration Scale:**<br>1 (low) to 5 (high) | **Site Mean Score (non-VA respondents only)** |
|---|---|
| **VA Accessibility**: In general, how accessible do you feel VA services are to homeless veterans in the community? | 3.41 |
| **VA Service Coordination**: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency. | 3.45 |